

Revised: 11/17/23

*2023 Fall National Meeting  
Orlando, Florida*

### HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE

Saturday, December 2, 2023

2:30 – 4:00 p.m.

Hilton Orlando Bonnet Creek—Bonnet Creek IV–XII & Corridor 1—Level 1


#### ROLL CALL

Anita G. Fox, Chair	Michigan	Mike Chaney	Mississippi
Jon Pike, Co-Vice Chair	Utah	D.J. Bettencourt	New Hampshire
Mike Kreidler, Co-Vice Chair	Washington	Glen Mulready	Oklahoma
Trinidad Navarro	Delaware	Andrew R. Stolfi	Oregon
John F. King	Georgia	Michael Humphreys	Pennsylvania
Dean L. Cameron	Idaho	Alexander S. Adams Vega	Puerto Rico
Kathleen A. Birrane	Maryland	Allan L. McVey	West Virginia
Grace Arnold	Minnesota		

NAIC Support Staff: Jolie H. Matthews/Brian R. Webb/Jennifer R. Cook

#### AGENDA

1. Consider Adoption of its Nov. 2 and Summer National Meeting Minutes Attachment One  
—*Director Anita G. Fox (MI)*
2. Consider Adoption of its Subgroup, Working Group, and Task Force Reports  
—*Director Anita G. Fox (MI)*
  - A. Consumer Information (B) Subgroup—*LeAnn Crow (KS)*
  - B. Health Innovations (B) Working Group—*Commissioner Nathan Houdek (WI)*
  - C. Health Actuarial (B) Task Force—*Commissioner Andrew N. Mais (CT)*  
*and Paul Lombardo (CT)*
  - D. Regulatory Framework (B) Task Force—*Commissioner Sharon P. Clark (KY)*
  - E. Senior Issues (B) Task Force—*Commissioner Barbara D. Richardson (AZ)*
3. Receive an Update from the Consumer Information (B) Subgroup on Work Regarding Consumer Education on Claim Appeal Rights—*LeAnn Crow (KS)*
4. Hear a Discussion on State-Based Exchange (SBE) Activities:
  - Georgia—*Gregg Conley (GA)*
  - Virginia—*Keven Patchett (VA)*

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5. Hear a Federal Update on Pharmacy Benefit Managers (PBMs), Medicare Advantage (MA) Marketing, Federal Regulations, and Federal Court Cases—*Brian R. Webb (NAIC)*
  6. Hear an Update from the federal Centers for Medicare & Medicaid Services' (CMS') Center for Consumer Information and Insurance Oversight (CCIIO) on its Recent Activities, including its Medicaid Redetermination Efforts—*Dr. Ellen Montz (CCIIO)*
  7. Discuss Committee Activities and Accomplishments Related to its Priorities for the Year—*Director Anita G. Fox (MI)*
  8. Discuss Any Other Matters Brought Before the Committee—*Director Anita G. Fox (MI)*

**Agenda Item #1**

**Consider Adoption of its Nov. 2 and Summer National Meeting Minutes  
—*Director Anita G. Fox (MI)***

Draft: 11/21/23

Health Insurance and Managed Care (B) Committee  
Virtual Meeting  
November 2, 2023

The Health Insurance and Managed Care (B) Committee met Nov. 2, 2023. The following Committee members participated: Anita G. Fox, Chair (MI); Jon Pike, Co-Vice Chair (UT); Mike Kreidler, Co-Vice Chair, represented by Ned Gaines (WA); Trinidad Navarro represented by Jessica Luff (DE); John F. King represented by Martin Sullivan (GA); Dean L. Cameron represented by Shannon Hohl (ID); Kathleen A. Birrane represented by Jamie Sexton (MD); Grace Arnold represented by Peter Brickwedde (MN); D.J. Bettencourt (NH); Mike Chaney represented by Bob Williams (MS); Glen Mulready represented by Ashley Scott (OK); Michael Humphreys (PA); and Allan L. McVey (WV). Also participating was: Sharon P. Clark (KY).

1. Adopted its Task Forces' 2024 Proposed Charges

Director Fox said the Committee's first item of business is to consider adoption of its task forces' 2024 proposed charges. She said that prior to today's meeting, NAIC staff distributed and posted on the Committee's web page all the task forces' 2024 proposed charges. She said the Health Actuarial (B) Task Force adopted its 2024 proposed charges on Sept. 26. The changes to the charges from its 2023 charges reflect the Long-Term Care Insurance (EX) Task Force's 2024 proposed charges, which, beginning in 2024, will come under the jurisdiction of the Committee. She said the Long-Term Care Insurance (EX) Task Force adopted its 2024 proposed charges Oct. 5.

Director Fox said the Regulatory Framework (B) Task Force adopted its 2024 proposed charges Sept. 29. She explained that as discussed during the Task Force's Sept. 29 meeting, because of timing issues with the white paper *A Guide to Understanding Pharmacy Benefit Manager and Associated Stakeholder Regulation* (white paper) and adopting its 2024 proposed charges, the Task Force decided to leave the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup's charges unchanged for now. She said that after the Task Force is reappointed in 2024, the Task Force's first order of business will be to discuss next steps for the Subgroup, including its 2024 charges.

Director Fox said the Senior Issues (B) Task Force adopted its 2024 proposed charges Oct. 30. She said its charges are unchanged from 2023.

Commissioner McVey made a motion, seconded by Commissioner Stolfi, to adopt the task forces' 2024 proposed charges. The motion passed unanimously.

2. Adopted its 2024 Proposed Charges

Director Fox said NAIC staff distributed and posted the Committee's 2024 proposed charges on the Committee's web page prior to the meeting. She said the only change from its 2023 charges is a new charge for the Committee to monitor the Long-Term Care Insurance (EX) Task Force's activities, which is consistent with other Committee charges.

Gaines made a motion, seconded by Commissioner Bettencourt, to adopt the Committee's 2024 proposed charges (Attachment One-A). The motion passed unanimously.

### 3. Adopted the White Paper

Director Fox said the Committee's next item on the agenda is to consider adoption of the white paper. She said that after extensive discussion, the Regulatory Framework (B) Task Force adopted the white paper Sept. 29. NAIC staff distributed and posted the white paper, as adopted by the Task Force, prior to this meeting. She said that as discussed during the Task Force's Sept. 29 meeting, the white paper reflects the extensive work and discussions of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup over the past two years. Director Fox acknowledged the Subgroup's difficult task in drafting the white paper to try to account for the differing opinions and perspectives of the various stakeholders involved. She said the white paper is intended to be a resource for those state insurance regulators wishing to learn more about pharmacy benefit manager (PBM) regulation and obtain a greater understanding of the prescription drug ecosystem. Director Fox said the Subgroup intends for the white paper to be considered a snapshot in time with the realization that, as appropriate, the Subgroup, or any successor NAIC group, might want to revise it in the future to reflect changes related to the complex issues discussed in the white paper, particularly with respect to any court decisions made after its adoption. Director Fox requested comments.

Commissioner McVey expressed West Virginia's support for the white paper's adoption even though West Virginia has more extensive laws related to PBMs than the laws discussed in the white paper. He said it is important that the information in the white paper is available to state insurance regulators who are interested in these issues. Commissioner Stolfi also expressed support for the white paper's adoption. For the edification of those in the meeting, he suggested that it would be appropriate to explain what a white paper is and what it is not. Director Fox said a white paper is meant to be a resource, a survey of a specific issue or issues, that the states can use as they see fit. It is not a model law. Commissioner Pike also expressed support for the white paper's adoption. He acknowledged that the white paper might not be perfect and probably will never be perfect, but it is a good resource for state insurance regulators to obtain information on issues related to PBM regulation and the role PBMs play in the prescription drug ecosystem.

Peter Fjelstad (Pharmaceutical Care Management Association—PCMA) said the PCMA continues to have concerns about and problems with the substance of the white paper, as well as the process used to draft it. He said the PCMA believes its concerns are reflected in the Regulatory Framework (B) Task Force's vote to adopt the white paper during its Sept. 29 meeting. He reiterated that the PCMA's main concerns are that the white paper is not a consensus document and contains incomplete data references. In addition, the PCMA believes the white paper is biased in its sourcing and language and includes inflammatory language. Fjelstad said that in summary, the PCMA believes the white paper's content and the drafting process have been far outside the scope of what was originally intended.

Carl Schmid (HIV+Hepatitis Policy Institute) expressed the NAIC consumer representatives' support for the white paper's adoption. He said the white paper is a good resource. He noted the NAIC consumer representatives' disappointment that the proposed NAIC model on PBMs did not receive sufficient votes for adoption and following that, the NAIC consumer representatives suggested the Subgroup develop a white paper to examine PBM regulation and the role PBMs play in the prescription drug ecosystem. Schmid also noted that the white paper does not include everything the NAIC consumer representatives wanted and the NAIC consumer representatives' disappointment in the removal the white paper's recommendation section prior to Regulatory Framework (B) Task Force's adoption of the white paper. He said the NAIC consumer representatives look forward to working with the NAIC group that will be charged with continuing the Subgroup's work to examine issues related to the prescription drug ecosystem.

Joel Kurzman (National Community Pharmacists—NCPA) acknowledged the Subgroup's work in drafting the white paper. He said PBMs are a threat to his members—the community pharmacists. He said the NCPA was also

disappointed that the white paper's recommendation section was removed. Kurzman also noted the extensive comments the NCPA submitted, which it believed should have been reflected in the white paper. He said that although the NCPA is disappointed that its comments were not included, the NCPA supports its adoption. He said the NCPA also looks forward to working with the NAIC group that continues the Subgroup's work beginning in 2024.

J.P. Wieske (Horizon Government Affairs—HGA) discussed the history related to the PBM white paper. He explained that when he chaired the Task Force on behalf of Wisconsin, in 2018, the Task Force established the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup because of the discussion by the Executive (EX) Committee members and Plenary during the adoption of the revisions to the *Health Carrier Prescription Drug Benefit Management Model Act* (#22). He said concerns were raised that the revisions to Model #22 did not directly regulate the activities of PBMs in their role as managers of prescription drug benefits. He noted that after the proposed PBM model, which would have established a licensing or registration process for PBMs, failed to receive sufficient votes for adoption, the Subgroup turned to developing a white paper to educate state insurance regulators on PBM regulation and the role PBMs play in the prescription drug ecosystem because of this strong interest in learning more about these issues. He said that after more than four years of looking at these issues, he believes the white paper is a great step forward in time and urged the Committee to adopt the white paper.

Commissioner Clark acknowledged the various comments noting that many of the same comments were expressed during the Regulatory Framework (B) Task Force's meeting prior to its adoption of the white paper. She said that from her legislative experience, given the fact that not everyone is satisfied with the white paper's contents means the Subgroup did a pretty good job in balancing stakeholder competing opinions and interests. She urged the Committee's adoption of the white paper.

Kris Hathaway (America's Health Insurance Plans—AHIP) acknowledged the Subgroup's hard work in drafting the white paper. She noted, however, that AHIP still has concerns about what it believes is biased language in the white paper and the white paper's tone in certain areas. She said that despite the Subgroup's intent that the white paper be considered a snapshot in time, AHIP remains concerned about some of the language in the white paper's provisions discussing legal case law. Hathaway said that because the Committee's adoption is the final stage in the process for the white paper, AHIP believes it would be appropriate to label the white paper to reflect in some manner, such as its title page, that it was not adopted by the Executive (EX) Committee and Plenary. Director Fox said she appreciates AHIP's comment, but she does not believe it is necessary to include such language or designation.

Commissioner Stolfi made a motion, seconded by Commissioner Pike, to adopt the white paper (Attachment One-B). The motion passed.

#### 4. Discussed the Committee's NAIC Connect Page

Director Fox said the NAIC Member Services Division recently approached her and members of her staff suggesting that the Committee be the next group of NAIC groups to begin actively using the NAIC Connect platform. She reminded the Committee that the Special (EX) Committee on Race and Insurance's Health Workstream is a pilot group and has already launched its page. Director Fox noted the ability of the NAIC Connect platform to provide NAIC members with a more unified experience for communicating with each other and sharing information and resources.

Director Fox said she anticipates the Committee's page on the NAIC Connect platform will be open and ready for its use in the next few weeks. She said that during the Committee's regulator-to-regulator meeting at the Fall National Meeting, NAIC staff will provide a demonstration of the Committee's page on NAIC Connect. She said

many Committee members have already activated their accounts on NAIC Connect. She urged those Committee members who have not activated their accounts to do so prior to the Fall National Meeting.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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## Draft Pending Adoption

Draft: 8/22/23

Health Insurance and Managed Care (B) Committee  
Seattle, Washington  
August 14, 2023

The Health Insurance and Managed Care (B) Committee met in Seattle, WA, Aug. 14, 2023. The following Committee members participated: Anita G. Fox (MI), Chair; Jon Pike, Co-Vice Chair (UT); Mike Kreidler, Co-Vice Chair (WA); Trinidad Navarro represented by Jessica Luff (DE); John F. King (GA); Dean L. Cameron (ID); Kathleen A. Birrane (MD); Grace Arnold (MN); Mike Chaney represented by Bob Williams (MS); D.J. Bettencourt (NH); Glen Mulready (OK); Andrew R. Stolfi (OR); Michael Humphreys (PA); and Allan L. McVey represented by Erin K. Hunter (WV). Also participating were: Paul Lombardo (CT); LeAnn Crow (KS); Troy Downing (MT); Eric Dunning and Martin Swanson (NE); and Scott A. White (VA).

### 1. Adopted its June 29 and Spring National Meeting Minutes

The Committee met June 29 and March 23. During its June 29 meeting, the Committee took the following action: 1) heard presentations on the Maryland, Michigan, and Nebraska state appeal programs; and 2) received an update on the Consumer Information (B) Subgroup's work to educate consumers on their claim appeal rights.

Williams made a motion, seconded by Commissioner King, to adopt the Committee's June 29 (Attachment One) and March 23 (*see NAIC Proceedings – Spring 2023, Health Insurance and Managed Care (B) Committee*) minutes. The motion passed unanimously.

### 2. Adopted its Subgroup, Working Group, and Task Force Reports

Williams made a motion, seconded by Commissioner King, to adopt the following reports: 1) the Consumer Information (B) Subgroup, including its May 25 minutes (Attachment Two); 2) the Health Innovations (B) Working Group, including its Aug. 14 minutes (Attachment Three); 3) the Health Actuarial (B) Task Force; 4) the Regulatory Framework (B) Task Force; and 5) the Senior Issues (B) Task Force. The motion passed unanimously.

### 3. Discussed Referrals to the Health Actuarial (B) Task Force

Director Fox said the Committee received a referral from the Financial Analysis (E) Working Group, asking the Committee to engage in a discussion with the federal Centers for Medicare & Medicaid Services (CMS) about state insurance regulators' concerns with how the risk adjustment formula impacts the current or prospective financial solvency position of new health insurers entering the health insurance marketplaces. She said that from the NAIC groups under the Committee, the Health Actuarial (B) Task Force is the group best suited to work on this referral. She said that assuming the Committee agrees to refer this issue to the Task Force, the referral will ask the Task Force to: 1) reach out to the CMS to discuss the issue; and 2) identify the changes, if any, in the formula to address the issue identified in the Working Group's referral to the Committee.

Director Fox said the second referral to the Health Actuarial (B) Task Force concerns how possible changes to the cost-sharing reduction subsidy, such as changes to silver loading, could impact plan options and costs to consumers. She said the Task Force has already heard from the American Academy of Actuaries (Academy) and other actuarial groups that silver loading has created odd incentives in the market. Because of this, Director Fox said she believes it would be beneficial for the Committee to know more about how changes in state silver loading policies or other changes, such as the elimination of the enhanced subsidies in 2026, could affect consumer



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choices and the affordability of coverage. She said assuming the Committee agrees to this referral, the Committee would be asking the Task Force to review this issue and report its findings to the Committee.

Commissioner Stolfi made a motion, seconded by Commissioner King, to refer the issues identified in the Financial Analysis (E) Working Group referral letter to the Committee and the issue on how possible changes to the cost-sharing reduction subsidy could impact plan options and costs to consumers to the Health Actuarial (B) Task Force. The motion passed unanimously.

### 4. Received an Update on Market Regulation and Consumer Affairs (D) Committee Work of Interest to the Committee

Director Fox said that in accordance with the Committee's charge to coordinate with appropriate Market Regulation and Consumer Affairs (D) Committee groups, as necessary, on health benefit plan and producer enforcement issues, she asked Commissioner Pike, chair of the Market Regulation and Consumer Affairs (D) Committee, to provide an update on the work of that Committee of interest to this Committee. Commissioner Pike asked Swanson to provide an update on the work of the Improper Marketing of Health Insurance (D) Working Group concerning revisions to the *Unfair Trade Practices Act* (#880). Swanson said that after several meetings and numerous discussions, during its meeting on Aug. 14, the Working Group adopted revisions to Model #880 to address regulatory and enforcement issues with health insurance lead generators.

### 5. Received an Update on the Consumer Information (B) Subgroup's Work Related to Educating Consumers on Claim Appeal Rights

Crow provided an update on the work of the Consumer Information (B) Subgroup related to educating consumers on their claim appeal rights. She said the Subgroup's small drafting subgroup, which the Subgroup established to review the Subgroup's previous work in 2021 on claims, has met three times since the Committee's July 29 meeting and plans to meet again after the Summer National Meeting. She said the small drafting group includes an array of stakeholders, including state insurance regulators and consumer representatives. She said the small drafting group decided to update its series of consumer guides on claims: 1) codes and claims; 2) explanation of benefits; 3) filing health insurance claims; 4) how to appeal a denied claim; and 5) understanding medical necessity. She said the 2021 version of these guides are available on the Subgroup's webpage on the NAIC website under the "Documents" tab.

Crow said the Subgroup hopes to have updated versions of the guides completed within the next few months. She said the Subgroup's goal is to create content that allows states to incorporate it into their own materials and to use it as-is with no additional configuration needed. The Subgroup is also considering ways to break the content into pieces that can be used in social media posts or in videos. She said that for the updated complete guides, the Subgroup wants to make them more interactive rather than the static PDF format. Crow said the NAIC Communications Division staff have been participating in the small drafting group meetings. She said the Subgroup plans to use their expertise and assistance in making the guides attractive and more accessible to consumers.

Crow said that as mentioned during her update to the Committee during its June 29 meeting, the Subgroup recognizes that developing documents like the guides is only one part of engaging consumers with health insurance issues. Consumers will only find its documents if they seek them out or if they come across communication from a state insurance department that engages them and inspires them to learn more. She said the Subgroup encourages the Committee and the NAIC to consider additional strategies for building knowledge among consumers and establishing state departments of insurance (DOIs) as a go-to source for assistance and education on health insurance.

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Williams asked if the Subgroup's consumer guides could be shared with the Mississippi Insurance Department to possibly supplement the information it currently has on its website about health insurance. Crow said she would share this information with him. Director Fox agreed that one of the main goals of the Consumer Information (B) Subgroup's work is to be able to share the guides with state DOIs to better assist them with helping their consumers.

### 6. Heard a Panel Discussion on Preventive Services

Carl Schmid (HIV + Hepatitis Policy Institute), Amy Killelea (Killelea Consulting), and Anna Howard (American Cancer Society Cancer Action Network—ACS CAN) gave a panel presentation on preventive services from a consumer-focused perspective. The presentation also discussed the methodology, findings, and recommendations included in the recently issued NAIC consumer representatives' report, *Preventive Services and Coverage and Cost-Sharing Protections Are Inconsistently and Inequitably Implemented: Considerations for Regulators*. Schmid provided an overview of the federal Affordable Care Act's (ACA's) preventive service requirements and the recent court case, *Braidwood v. Becerra*, challenging those requirements. He also discussed the health equity implications of increasing access to preventive services. Schmid cited the four preventive services examined in the NAIC consumer representatives' report that have such health equity implications: 1) smoking cessation; 2) pre-exposure prophylaxis (PrEP) for the prevention of human immunodeficiency virus (HIV); 3) colorectal cancer screening; and 4) postpartum depression screening. He explained that the NAIC consumer representatives commissioned the report because despite the ACA preventive care requirements for coverage and no cost-sharing for such services, compliance with such requirements has been a challenge for certain preventive services, particularly with respect to HIV preventive care services, including prescription drugs needed to manage the virus.

Killelea discussed the NAIC consumer representatives' preventive services report's methodology and findings. She said the report found that: 1) consumer-facing documents lack comprehensive preventive services descriptions; 2) plan formularies did not always describe zero-dollar cost-sharing preventive medications clearly and accurately; and 3) payer guidance documents that inform claims adjudication policies were often incomplete. She provided examples for each of these findings. She also explained why payer guidance matters because incomplete, unarticulated specific coverage payer policies that fail to inform claims adjudication policies for providers lead to arbitrary coverage decisions.

Howard discussed the recommendations included in the report for state insurance regulators to address the issues in the report's findings, which include using data calls and market conduct examinations to assess compliance, ensuring continued preventive protections with state legislative and regulatory action, establishing uniform billing and coding standards, and holding plans accountable for educating consumers and providers on preventive services requirements.

Schmid asked if the Consumer Information (B) Subgroup has developed materials on preventive services, and if not, if the Subgroup would consider developing such materials. Crow said that the Subgroup has not developed specific materials on preventive services, but because the Subgroup also believes this is an important consumer issue, she would ask the Subgroup to develop consumer education materials on it.

### 7. Heard an Update on the Medicaid Redetermination Process

Miranda Motter (America's Health Insurance Plans—AHIP) provided a status update on the Medicaid redetermination process following the end of the COVID-19 public health emergency (PHE). She discussed key findings from the first batch of Medicaid redeterminations data the CMS reported last month in accordance with the federal Consolidated Appropriations Act, 2023. She said that as of April 2023, based on 14 states, more than 2 million people have gone through the full renewal process. Of those, nearly half (45.5%) were successfully

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reenrolled in Medicaid and Children's Health Insurance Program (CHIP), and more than half (55%) of those renewed were done automatically. She said that approximately, one-third (32.2%) lost their Medicaid and/or CHIP coverage and within that group, 79% of those terminations were for procedural reasons. Motter said that it is anticipated that the next CMS update will provide data on coverage transitions for those who were determined no longer eligible for Medicaid.

Motter discussed updated state renewal timelines. She also discussed new state flexibilities the U.S. Department of Health and Human Services (HHS) recently announced to help keep Americans covered as states resume Medicaid and CHIP renewals. She also provided information on federal, state, and health industry resources for consumers and employers to assist them with transitioning through the renewal process and maintaining coverage. She highlighted AHIP's Medicaid redetermination toolkit designed to assist consumers transitioning from Medicaid coverage because of redetermined ineligibility for such coverage to other types of coverage, such as employer-based health insurance and health insurance marketplace plans. She also discussed the work of the Connecting to Coverage Coalition (Coalition), which is a coordinating community for stakeholders working to minimize disruptions in coverage associated with Medicaid redeterminations. She said the Coalition includes broad representation from seniors, disability groups, patient groups, provider associations, employer-related organizations, consumer advocacy groups, and Medicaid trade associations.

### 8. Received an Update on the Work of the Special (EX) Committee on Race and Insurance Health Workstream

Commissioner Arnold and Commissioner Birrane provided an update on the Special (EX) Committee on Race and Insurance Health Workstream work since its last update to the Committee.

Commissioner Arnold said that after the Spring National Meeting, the Workstream met in a regulator-only session to discuss its activities and meetings for 2023, during which, the Workstream decided to: (1) continue its education on benefit design relating to specific areas of focus, such as preventative care and mental health coverage beyond pure parity; (2) explore the evolution of the ACA section 1332 waivers and innovative uses of them that can be implemented to lower the uninsured rate in states; and (3) continue to provide a forum for sharing innovative programs and initiatives that states are doing that are designed to promote health equity. She said the Workstream met July 24 to hear presentations focusing on preventative care and lowering barriers to such care, particularly with respect to chronic diseases. The presentations discussed the impact of lowering barriers to such care in increasing health equity and reducing disparities. The Workstream plans to hold a follow up meeting on this topic sometime in October or early November. Commissioner Arnold said the Workstream plans to meet sometime in late September or early October to hear presentations on initiatives and programs to reduce mental health disparities. The Workstream hopes to hear from a variety of stakeholders, including industry and consumers.

Commissioner Birrane said the Workstream plans to meet Sept. 19 to hear presentations on innovative uses for ACA section 1332 waivers and other market reforms, aimed toward lowering the uninsured rate in the states. She said during this meeting, the Workstream will hear from states that have found success in amending their state benchmark plans, what they changed, and what that process looked like. Further, the Workstream will hear from states that have implemented other market reforms to make health insurance more accessible. She said the Workstream looks forward to hearing what has proven successful, what challenges arose, and what recommended best practices emerged as these efforts were undertaken to assist the uninsured population in respective states.

Commissioner Arnold said the Workstream is also piloting a new collaboration space on the NAIC Connect platform to allow Workstream members and other NAIC members to discuss issues related to health equity and other related topics. She said this effort will provide a platform that Workstream members can use to share the information that has and will be captured during its past and future meetings on removing barriers to health insurance for historically disadvantaged communities with each other and other NAIC members. She said the

## **Draft Pending Adoption**

Workstream's NAIC Connect page will be a living resource for the NAIC membership on which the Workstream can continue to build content and resources for states seeking to address the equity gap in health insurance access and utilization.

Commissioner Arnold said that due to the hard work of the NAIC Member Services Division, the Workstream's NAIC Connect platform page is scheduled to go live within the next few weeks as part of the initial pilot rollout along with the Innovation, Cybersecurity, and Technology (H) Committee. She encouraged anyone interested to visit the Workstream's page and test it out during the pilot phase. The Workstream has planned a meeting on Sept. 21 to walk Workstream members through the features and content on the page.

Lastly, Commissioner Birrane said that the Workstream has been working in collaboration with the Committee and the Big Data and Artificial Intelligence (H) Working Group to prepare a survey of artificial intelligence (AI) use by health insurers. She said Maryland has been doing the initial coordination of this work with the assistance of the Johns Hopkins Bloomberg School of Health. She said Maryland expects to have a draft survey form soon to share with the collaborating groups as it finalizes a draft to share with the industry for refinement. She said Maryland's goal is to solicit participating states and have the survey out this year.

Having no further business, the Health Insurance and Managed Care (B) Committee adjourned.

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**Agenda Item #2**

**Consider Adoption of its Subgroup, Working Group and Task Force Reports**  
**—*Director Anita G. Fox (MI)***



*Virtual Meetings*

**CONSUMER INFORMATION (B) SUBGROUP**

November 21, 2023 / October 25, 2023 / October 17, 2023 / September 18, 2023

**Summary Report**

The Consumer Information (B) Subgroup met Nov. 21, Oct. 25, Oct. 17, and Sept. 18, 2023. During these meetings, the Subgroup:

1. Discussed and adopted the documents titled *Filing Health Insurance Claims, Explanation of Benefits, Understanding Medical Necessity, and How to Appeal a Denied Claim*.
2. Discussed and adopted revisions to the *Frequently Asked Questions About Health Care Reform* (FAQ) document, which is a resource for department of insurance (DOI) staff when responding to consumer questions about the Affordable Care Act (ACA) and related topics.

Draft: 11/27/23

Consumer Information (B) Subgroup  
E-Vote  
November 21, 2023

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Nov. 21, 2023. The following Subgroup members participated: LeAnn Crown, Chair (KS); Anthony L. Williams (AL); Debra Judy (CO); Randy Pipal (ID); Michelle Baldock (IL); Carrie Couch (MO); Susan Brown (MT); Nichole Faulkner (NC); David Buono (PA); Jill Kruger (SD); Vickie Trice (TN); Shelley Wiseman (UT); Todd Dixon (WA); and Christina Keely (WI).

1. Adopted Revised Guides on Claims and Appeals

The Subgroup conducted an e-vote to consider adoption of the documents titled *Filing Health Insurance Claims, Explanation of Benefits, Understanding Medical Necessity, and How to Appeal a Denied Claim* (Attachment 1). The guides provide information for consumers about the claims and appeals process for health insurance. The motion passed unanimously.

Having no further business, the Consumer Information (B) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/B CMTE/National Meetings/2023 Fall National Meeting/Final Minutes/Cons Info 11.21 evote

Draft: 11/9/23

Consumer Information (B) Subgroup  
E-Vote  
October 25, 2023

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee conducted an e-vote that concluded Oct. 25, 2023. The following Subgroup members participated: LeAnn Crow, Chair (KS); Debra Judy (CO); Randy Pipal (ID); Carrie Couch (MO); Susan Brown (MT); Nichole Faulkner (NC); David Buono (PA); Vickie Trice (TN); Shelley Wiseman (UT); and Christina Keely (WI).

1. Adopted Revisions to *Frequently Asked Questions About Health Care Reform*

The Subgroup conducted an e-vote to consider adoption of *Frequently Asked Questions About Health Care Reform* (Attachment 1), which is a resource for department of insurance (DOI) staff when responding to consumer questions about the Affordable Care Act (ACA) and related topics. The motion passed unanimously.

Having no further business, the Consumer Information (B) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/B CMTE/National Meetings/2023 Fall National Meeting/Final Minutes/Cons Info 10.25 evote



Draft: 11/9/23

Consumer Information (B) Subgroup  
Virtual Meeting  
October 17, 2023

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Oct. 17, 2023. The following Subgroup members participated: LeAnn Crow, Chair (KS); Anthony L. Williams (AL); Debra Judy (CO); Randy Pipal (ID); Mary Kwei (MD); Carrie Couch (MO); Susan Brown (MT); Nichole Faulkner (NC); Rebecca Ross (OK); Jill Kruger (SD); Vickie Trice and Jennifer Ramcharan (TN); Shelley Wiseman (UT); and Christina Keeley (WI). Also participating was: Cynthia Cisneros (NM).

1. Discussed Consumer Assistance on Claim Denials and Appeals

Crow reviewed work on the claim denials and appeals content from the Subgroup's small drafting group. She said a number of the guides have been completed, and the drafting group is working to finish the guide, *How to Appeal a Denied Claim*. She said any member or interested party is welcome to join the drafting group.

Crow said the appeals guide explains the process for consumers to appeal denied claims after a service is delivered, but it does not explain prior authorization denials. She said the drafting group discussed whether another guide is needed to cover prior authorization denials and coding issues. She asked the Subgroup whether an additional guide should be part of the claims and appeals package under development or if it should be a separate document that the Subgroup works on in 2024. Several Subgroup members expressed support for delaying work on a new guide until 2024. Crow said the Subgroup would plan for that schedule and include its plans in its update to the Health Insurance and Managed Care (B) Committee at the Fall National Meeting.

Crow said that the Subgroup plans to get input from Brenda J. Cude (University of Georgia), as well as the NAIC Communications team, on the revised guides once it has completed updates to the content.

2. Discussed the FAQ About Health Care Reform

Crow said the Subgroup reviews and updates the *Frequently Asked Questions About Health Care Reform* (FAQ) each year before open enrollment begins. She thanked volunteers who reviewed sections of the FAQ and suggested updates. She said the FAQ is intended to be used by state insurance regulators rather than directly by consumers.

Crow said the volunteers made relatively few edits. She asked those who reviewed the document to raise any questions on items they were unsure of or issues they would like to discuss with the Subgroup. Wayne Turner (National Health Law Program—NHLP) said his edits were somewhat more extensive than others. He said he added a reference to health care sharing ministries (HCSMs). The Subgroup discussed whether more explanation should be added to clarify that HCSMs are not insurance. Ross added that one state does require HCSMs to be licensed as insurers. The Subgroup decided to accept the additional reference.

Turner explained his edit to clarify metal tiers and the out-of-pocket costs associated with bronze plans. He highlighted an addition to federal requirements on prescription drug formularies and provider networks. He also described his changes clarifying the distinctions between navigators, application assisters, and brokers. He further explained edits on preexisting condition protections and preventive services. He asked the Subgroup to consider a more extensive guide on preventive services in 2024. Dr. Cude suggested edits to further clarify the requirements

around network providers and no-cost preventive services. Turner also requested that the document be updated to remove the binary gender terms “he” and “she” and use “they” as a singular pronoun. The Subgroup agreed to accept this suggestion.

Crow said the Subgroup would conduct an e-vote to consider adoption of the FAQ. She said the approved FAQ would be distributed through the Health Update list, the Subgroup’s email list, and the Subgroup’s website.

Having no further business, the Consumer Information (B) Subgroup adjourned.

NAIC Support Staff Hub/B CMTE/National Meetings/2023 Fall National Meeting/Cons Info 10.17

Draft: 10/6/23

Consumer Information (B) Subgroup  
Virtual Meeting  
September 18, 2023

The Consumer Information (B) Subgroup of the Health Insurance and Managed Care (B) Committee met Sept. 18, 2023. The following Subgroup members participated: LeAnn Crow, Chair (KS); Anthony L. Williams (AL); Debra Judy (CO); Randy Pipal (ID); Mary Kwei (MD); Carrie Couch (MO); Rebecca Ross (OK); Vickie Trice and Jennifer Ramcharan (TN); Shelley Wiseman (UT); and Christina Keeley (WI). Also participating was: Cynthia Cisneros (NM).

1. Discussed Consumer Assistance on Claim Denials and Appeals

Crow reviewed work on claim denials and appeals content from the Subgroup's small drafting group. She said states are interested in data that show few consumers appeal claim denials. She said there were five consumer briefs on the claims process completed in 2021, and a drafting group has been reviewing and revising them. She said state insurance regulators, consumer representatives, and other interested parties have participated in the drafting group. She said others are also welcome to join the drafting group.

Crow said the drafting group has worked on two briefs so far: Filing Health Care Claims and Explanations of Benefits. She said the drafting group is ready to take on two more: Understanding Medical Necessity and How to Appeal Denied Claims. She said the drafting group has discussed how to make the documents more interactive and appealing to readers. She encouraged the full Subgroup to review the documents and suggest edits to make them easy to use for both insurance departments and consumers. She said Brenda J. Cude (University of Georgia) has offered to review the documents for readability once the Subgroup has made its revisions.

Bonnie Burns (Consultant to Consumer Groups) asked whether the guide on appeals could include directions on how enrollees in Medicare and Medicaid can appeal claims denials. Crow said it is a good suggestion.

Harry Ting (Health Consumer Advocate) shared information on a preventive services study that was commissioned by consumer representatives. He said there have been instances when consumers were not aware of their preventive services coverage, as well as instances when insurers created barriers to receiving preventive services. He also said preventive services should be addressed in the *Frequently Asked Questions About Health Care Reform* report. He asked if the report could be posted on the Subgroup's web page. Joe Tuschner (NAIC) clarified that the report is available on the NAIC/Consumer Liaison Committee's web page.

2. Discussed the *Frequently Asked Questions About Health Care Reform* Report

Crow said the Subgroup reviews and updates the *Frequently Asked Questions About Health Care Reform* report each year. She said the report is intended to be used by state insurance regulators rather than consumers. She said revisions should cover updates such as new income thresholds for subsidy eligibility and any other policy changes over the last year. She said the Subgroup's goal is to revise the report before open enrollment in the federal marketplace begins Nov. 1.

Crow said it has worked well in the past to split up the document by its sections so Subgroup members can choose one or two to review and update. She said she would like to follow a similar procedure this year. She asked for volunteers to select sections to work on and make revisions by Oct. 13. Several Subgroup members volunteered, and Crow asked others to follow up by email to volunteer.

Burns asked whether the report addresses private exchanges operated by employers to allow their employees to select health plans. She questioned whether private exchanges limit employees' health insurance choices. Tuschner responded that the report does not address private exchanges since it is focused on the federal Affordable Care Act (ACA) and health care reform.

Having no further business, the Consumer Information (B) Subgroup adjourned.

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/National Meetings/2023 Fall National Meeting/Final Minutes/Cons Info Minutes 9.18.pdf

*2023 Fall National Meeting*

*Orlando, Florida*

**HEALTH INNOVATIONS (B) WORKING GROUP**

Friday, December 1, 2023

10:00 – 11:00 a.m.

**Meeting Summary Report**

The Health Innovations (B) Working Group met Dec. 1, 2023. During this meeting, the Working Group:

1. Adopted its Summer National Meeting minutes.
2. Heard a presentation from the Centers for Medicare & Medicaid Services (CMS) Innovation Center on the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. The presenter explained the model's goals and how state insurance regulators can help facilitate state participation.
3. Heard a presentation from AHIP on value-based care. The presenter described progress in moving to value-based arrangements, best practices in data sharing, and recommendations from the organization for improving value-based care.

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### HEALTH ACTUARIAL (B) TASK FORCE

Thursday, November 30, 2023

2:30 – 4:00 p.m.

#### Meeting Summary Report

The Health Actuarial (B) Task Force met Nov. 30, 2023. During this meeting, the Task Force:

1. Adopted its Summer National Meeting minutes.
2. Adopted its Sept. 26 minutes, which included the following action:
  - A. Adopted its 2024 proposed charges.
  - B. Discussed a federal Affordable Care Act (ACA) referral from the Health Insurance and Managed Care (B) Committee.
  - C. Heard a presentation from the Blue Cross Blue Shield Association (BCBSA) on risk adjustment in the individual federal ACA market.
3. Adopted the report of the Long-Term Care Actuarial (B) Working Group, which met Nov. 30. During this meeting, the Working Group took the following action:
  - A. Adopted its Oct. 2 minutes, which included the following action:
    - i. Discussed a referral from the Health Risk-Based Capital (E) Working Group to add language to *Actuarial Guideline LI—The Application of Asset Adequacy Testing to Long-Term Care Insurance Reserves (AG 51)* that clarifies that regardless of which annual statement blank an insurer files, it must make an AG 51 filing if the AG 51 filing requirement criteria are met.
    - ii. Discussed development of a single Long-Term Care Insurance (LTCI) Multistate Rate Review Approach.
  - B. Adopted a proposal to add language to AG 51 that clarifies that regardless of which annual statement blank an insurer files, it must make an AG 51 filing if the AG 51 filing requirement criteria are met.
  - C. Heard an update on the development of a single LTCI Multistate Rate Review Approach.
4. Heard an update on Society of Actuaries (SOA) Research Institute activities.
5. Heard an update from the federal Center for Consumer Information and Insurer Oversight (CCIIO) on federal ACA risk adjustment issues.
6. Heard an update from the American Academy of Actuaries (Academy) Health Practice Council.
7. Heard an Academy professionalism update.

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## REGULATORY FRAMEWORK (B) TASK FORCE

Friday, December 1, 2023

12:00 – 1:00 p.m.

### Meeting Summary Report

The Regulatory Framework (B) Task Force met Dec. 1, 2023. During this meeting, the Task Force:

1. Adopted its Sept. 29 and Summer National Meeting minutes. During its Sept. 29 meeting, the Task Force took the following action:
  - A. Adopted its 2024 proposed charges:
  - B. Adopted the white paper *A Guide to Understanding Pharmacy Benefit Manager and Associated Stakeholder Regulation* (PBM white paper).
2. Adopted the report of the Accident and Sickness Insurance Minimum Standards (B) Subgroup, including its Oct. 2, Sept. 18, and Aug. 21 minutes. During these meetings, the Subgroup took the following action:
  - A. Completed its discussions of the comments received on the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act* (#171).
  - B. Exposed a revised draft of Model #171 for a public comment period that ended Dec. 1.
3. Adopted the report of the Employee Retirement Income Security Act (ERISA) (B) Working Group.
4. Adopted the report of the Mental Health Parity and Addiction Equity Act (MHPAEA) (B) Working Group, including its Aug. 14 minutes. The Working Group will meet Dec. 2. During this meeting, the Working Group plans to take the following action:
  - A. Hear a panel discussion of the federal rules on mental health parity.
  - B. Meet in regulator-to-regulator session, pursuant to paragraph 8 (consideration of strategic planning issues) of the NAIC Policy Statement on Open Meetings, to continue work on its goals.
5. Adopted the report of the Pharmacy Benefit Manager Regulatory Issues (B) Subgroup.
6. Heard a presentation from the HIV+Hepatitis Policy Institute on the results and impact of the copay accumulator adjustment programs lawsuit, which challenged a federal rule that allows health insurers to avoid counting the value of drug manufacturer copay assistance toward patients' out-of-pocket cost obligations. The presentation included a detailed analysis of the opinion overturning the federal rule.
7. Heard a presentation from the National Association of Benefits and Insurance Professionals (NABIP) on "Cost: The Greatest Barrier to Access," the major issue keeping health insurance brokers up at night. The presentation highlighted how health care costs are adversely affecting access to health care services. The presentation also offered a few suggestions to address the issues, such as identifying the



true cost drivers, giving attention to the plight of the underinsured, and focusing on social determinants of health.



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**SENIOR ISSUES (B) TASK FORCE**

Friday, December 1, 2023  
3:30 – 5:00 p.m.

**Meeting Summary Report**

The Senior Issues (B) Task Force met Dec. 1, 2023. During this meeting, the Task Force:

1. Adopted its Oct. 30 and Summer National Meeting minutes.
2. Questioned representatives from the Centers for Medicare & Medicaid Services (CMS) about Medicare Advantage marketing and better communication between the states and CMS.
3. Heard an update from the Long-Term Care (EX) Task Force on its work on reduced benefits options (RBOs) and any potential impact on the *Long-Term Care Insurance Model Act* (#640) and the *Long-Term Care Insurance Model Regulation* (#641).
4. Heard an update on the status of Minnesota’s “Own Your Future” initiative.
5. Heard an inquiry from North Dakota about how other states might be handling an issue it is facing regarding the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and eligibility to purchase Plan G.
6. Heard a request for the Task Force to look at a proposal to give Medicare Part D drug plan enrollees the same opportunity to switch plans as Medicare Advantage enrollees.

### **Agenda Item #3**

**Receive an Update from the Consumer Information (B) Subgroup on Work Regarding Consumer Education on Claim Appeal Rights—*LeAnn Crow (KS)***

## Health Care Bills: Explanation of Benefits

After you receive health care services and your health plan receives a claim for payment, your health plan will send you a document called an Explanation of Benefits or EOB.

### What is an EOB?

The EOB is not a bill. It's the health plan's explanation of how much it paid for the cost of services you received.

### What does an EOB tell me?

An EOB tells you:

- The services you received
- How much each health care professional or facility charged for services
- How much the health plan paid
- How much you may owe your health care professional or facility (provider), which may be labeled patient or member responsibility.

### What should I look for on an EOB?

Review the amount the EOB says you owe as your share of the bill. Compare that amount to:

- The bills from your health care providers, and
- What you've already paid.

If you have questions about the amounts shown, call your health care provider's billing office.

### What does an EOB look like?

Not all EOBs look alike, but here are a few things to look for on your EOB.

# EXPLANATION OF BENEFITS (EOB)



THIS IS NOT A BILL

MEMBER NAME [REDACTED]  
ID NUMBER [REDACTED]  
GROUP NAME [REDACTED]  
GROUP ID [REDACTED]

SERVICES RECEIVED	CLAIM STATUS	PROVIDER BILLED	INSURANCE PAID	YOU OWE PROVIDER	REMARK CODE
[REDACTED]	PAID	\$\$\$	\$\$	\$	
[REDACTED]	PAID	\$\$\$	\$\$\$		[REDACTED]

[REDACTED]

APPEAL INSTRUCTIONS [REDACTED]

- *Information about the person who received the services.* This includes the health plan ID number and the member name, sometimes identified as “patient.” If it’s your health plan, the EOB often refers to the patient as “self.” If the plan is through your spouse or parent, then their name may be on the EOB.
- *A list of services received, including the dates you received them.* There also may be billing codes to identify the services. If you need more information about billing codes, contact your health plan or health care professional’s billing office.
- *Information about the professional or facility.* This will name the person (doctor, nurse practitioner, psychologist, physical therapist, or others) or facility (laboratory, hospital) that provided the service.
- *The amount the professional or facility billed the health plan.*
- *The “allowed” amount.* This is the total amount that the health care professional (the provider) is allowed to collect from the health plan and patient. The health plan has negotiated the allowed amount with providers in-network in your health plan.
- *The amount the health plan paid for each service.*
- *The amount you owe the provider.* This may include money you paid during your visit. Remember the EOB is not a bill. Compare the amount the EOB says you owe to any bills from your health care professional or facility.

- *Information about denials and other details or notes.* The health plan may use codes to explain denial reasons and notes. You should see an explanation of the codes on the EOB.

### How else is an EOB helpful?

An EOB is an important tool to explain how much you owe and help you track how much you've spent out-of-pocket for covered health care costs. That helps you know how far along you are in meeting your deductible and out-of-pocket limit for the year. If you've reached your out-of-pocket limit and are asked to pay for services, you should contact your health plan right away.

You'll also find instructions on your EOB to file a grievance or [appeal](#) if the health plan denies coverage for services or pays less than you believe your plan should pay.

### Who receives an EOB?

Usually, the health plan sends the EOB to the primary person on the health plan. An employer who provides the insurance usually sends EOBs to the employee, including EOBs for a spouse and dependents on the plan.

You may ask the health plan to send your EOBs to a different address for confidential services or if the information on an EOB would put you in danger.

## Health Care Bills: Filing Health Insurance Claims

Health care you receive can be paid for in many ways. Depending on your health plan, you may be asked to pay part of the cost when you receive the care, sometimes as a co-pay. Your health plan may pay part or all of the remaining bill. But you may be responsible for the rest if the health plan doesn't pay all of the balance.

### When do I need to file a claim?

A claim is a request to a health plan to pay for health care. You may need to file a claim if you see an out-of-network health care professional who doesn't accept your health plan. When you see professionals or visit facilities in your health plan's network, they usually file the claim for you.

**If you need to file a claim with your health plan, here's what you need to know.**

### How do I file a claim with my health plan?

You'll find a claim form on most health plans' websites, along with information about how to submit the claim. Look at your health plan card for a website or a phone number to call for information about filing a claim.

### What will I need?

You'll need the following to file a claim:

- *An itemized bill from your health care professional or facility (provider).* The bill should include the date you received care, a description of services you received, the billing codes for each service, and the charge for each service. It's best to make a copy of the bill and attach it to your claim form. You may also need your professional's Tax Identification Number (TIN) and their National Provider Identification Number (NPI). This information should be on the bill.
- *The completed claim form.* You may be asked to provide your personal information, including social security number, health plan ID number, and, if you received treatment due to an accident or illness at work, your employment status. Answering all of the questions on the form will speed up the claim processing.

### More information

What if your health care was due to an accident or illness at work? A workers' compensation program, not your health plan, may be responsible for paying the claim. When you tell your health plan your treatment was due to an accident or illness at work, it may refer your claim to a state workers' compensation program.

### What if the form asks where to send payment?

The claim form may also ask where to send payment -- to your health care provider or to you. Please note: if you ask that the payment be sent to you, you'll be fully responsible for paying your health care professional or facility.

### When do I file the claim?

File the claim as soon as possible after you receive health care. Many health plans have a deadline to file the claim, for example, 90 days after you receive care. Contact customer service or check your health plan contract to learn your health plan's timeline.

### Where do I submit the claim?

You may be able to submit a claim on the health plan website. Review the claim form for more instructions. Or call the health plan at the number on your health plan card.

### What happens after I file the claim?

After you file the claim, your health plan has a limited time to tell you if it will pay the claim. How long your health plan has varies by state. (For help with denied claims, see the companion guide [How to Appeal a Denied Claim](#))

After your health plan processes a claim, it will send you a document called an *Explanation of Benefits* or *EOB*. The EOB will show how much your health plan will pay (See companion guide [Explanation of Benefits](#)). Your health plan may pay part or all of the claim based on your coverage. Remember, depending on how you filled out the claim form, the plan may send payment to you or to the health care provider. Check the EOB to know how much your plan has paid and how much you need to pay.

Your health care professional's billing office may send you a bill before your health plan has processed the claim. Call the professional's billing office and ask them to delay your payment until after the health plan has processed the claim.

## Health Care Bills: How to Appeal a Denied Health Plan Claim

After health care professionals or facilities (providers) treat you, they usually file a claim with your health plan for payment. Sometimes, the health plan refuses to pay part or all of the claim. If that happens, the health plan sends you and the provider reasons for the denial in an [Explanation of Benefits](#). In some cases, the denial can be reversed if your provider resubmits the claim with missing or corrected information. If you don't agree with the denial, you and/or the health care provider may file an appeal. You may also file an appeal if your health plan denies pre-approval (called prior authorization) for a benefit or service.

There are two types of appeals—an **internal appeal** and an **external review**.

### *Here are the steps you can take if your health plan denies a claim*

#### **File an Internal Appeal**

You file an *internal appeal* to ask your health plan to review its decision to deny a claim. A family member, your health care professional, or another person you trust can file an appeal for you and represent you in the appeal process. You'll need to give written permission for someone to represent you. To do this, follow your health plan's instructions to designate an *authorized representative*.

- The denial notice you receive will describe the process you must follow to start an appeal, including how long you have to submit the internal appeal to your health plan. If you can't find the information on the notice, look at your insurance card/materials or call the customer service number.
- An internal appeal usually requires filing a form or writing a letter. Be sure to include in the letter your name, claim number, health plan ID number, and any other information you have to support your claim. (See the sample letter later in this document.)
- If the health plan denied a claim for a [medical necessity](#) reason, contact your health plan and health care provider to learn what other information you'll need to file an appeal.

The health plan has a set amount of time after it receives your appeal to review it and make a decision. How much time the health plan has varies by state. If delaying medical care could harm your life, health, or ability to function, you can ask that the appeal be reviewed quickly ("on an expedited basis").

### *And if your health plan still says "No"....*

#### **Ask for an External Review**

If your health plan denies the claim after the internal appeal, you have the right to ask for an *external review*. An Independent Review Organization (IRO) may do the external review. You may have a limited time to ask for an external review after receiving an internal appeal decision.

- The notice of the decision from your internal appeal should include information about how to ask for an external review.
- You may be able to submit information you didn't include in your internal appeal to support your position.
- The external reviewer has a limited time to reach a decision.
- You'll receive a written notice of the decision.
- The health plan must pay the claim if the external review is decided in your favor.
- The result of the external review is final and binding against both you and the health plan.

### *Things to Keep in Mind*

#### **What is an Independent Review Organization?**



An Independent Review Organization (IRO) is a neutral third party that independently reviews an external appeal. An IRO isn't part of your health plan. It makes decisions based on medical evidence. Check with your state insurance department to learn more about your state's external review process.

### **Do I Need a Lawyer to File an Appeal?**

Your state insurance department can help you with appeals. You don't need an attorney to file an appeal or ask for an external review. But if you want help from a lawyer, contact your state bar association for more information about attorney referrals and low- or no-cost legal help. Low-income people, older adults, and persons with disabilities may qualify for free legal help.

### **Medicare and Medicaid**

If you're enrolled in Medicare or Medicaid, there are different rules for appeals.

- For Medicare, call 1-800-MEDICARE or your local [State Health Insurance Assistance Program](#) to ask for information about free help to appeal a decision.
- For Medicaid, contact your state's Medicaid agency for help.

### **Keep Records**

Keep detailed records, including copies of bills from your health care professional or facility, notices from your health plan, denial letters, appeal requests, and medical information related to your case. You and/or your authorized representative can ask for the medical records you need to support your appeal.

### **Take Detailed Notes and Set Response Deadlines**

Keep notes about the details of all communications, including dates/times and people's names. Ask about and make notes about any deadlines for your health plan to respond or send you information.

***Sample letter to request an internal appeal***  
*Add your own information when you see italics below.*

*Your Name*  
*Your Address*

*Date*

*Address of the Health Plan's Appeal Department*

*Re: Name of Insured*

*Plan ID#:*

*Claim #:*

To Whom It May Concern:

I am writing to request an appeal of your denial of the claim for treatment or services provided by *name of health care professional or facility on date provided.*

The reason for the denial was listed as *(reason listed for denial)*, but I have reviewed my policy and believe the *services* should be covered. *Here is where you may provide more detailed information about the situation. The appeal will be decided based on the coverage in your policy and medical evidence, so write short, factual statements. Do not include emotional wording. If you're including documents, include a list of what you're sending here. For example, you might include medical records or other clinical information from your health care professionals.*

If you need additional information, I can be reached at *telephone number and/or e-mail address.* I look forward to receiving your response as soon as possible.

Sincerely,

*Signature*

*Typed Name*  
*Telephone Number*  
*Email address*

## Health Care Bills: Understanding Medical Necessity

### What is medical necessity?

Typically, health insurance plans only cover “medically necessary” health care. So, what does that mean?

Every health plan has its own definition of medical necessity. Plans use specific criteria to decide if health care is medically necessary. Medically necessary treatments or services:

- Evaluate, diagnose, or treat an illness, injury, disease, or its symptoms;
- Follow generally accepted standards of medical practice;
- Are “clinically appropriate,” meaning the level of care would be effective to treat the patient’s illness, injury, or disease;
- Aren’t primarily for the convenience of the patient, health care professional, or insured’s family;
- Don’t cost more than another service or series of services that would be at least as effective; and
- Aren’t for experimental, investigational, or cosmetic purposes.

### How does medical necessity affect coverage of my health care?

Plans only cover health care they determine is medically necessary. Examples of services or treatments a plan may define as **not** medically necessary include cosmetic procedures, treatments that haven’t been proven effective, and treatments more expensive than others that are also effective.

### When is medical necessity determined?

In a “prior authorization review,” the plan decides if a requested treatment or service is medically necessary *before* it is provided. The health plan typically reviews a health care professional’s Letter of Medical Necessity, medical records, and the plan’s medical guidelines.

In a “concurrent review,” the plan decides if the treatment or service is medically necessary *while* you’re receiving it, for instance while you’re receiving in-patient care at a hospital.

In a “retrospective review,” the plan decides if health care already provided was medically necessary or, in the case of emergency services, whether you required emergency care. The decision is made *after* you receive the care.

### What are medical guidelines?

All plans follow guidelines that determine if health care is within the medical community’s accepted standards. A plan must make its medical guidelines available to you if it used them to decide to deny you coverage. If a health plan doesn’t give you its medical guidelines, or if the guidelines don’t reflect generally accepted clinical standards, you can [file an appeal](#) and/or complain to your state insurance department.

### What if I disagree with my health plan about medical necessity?

If your health plan denied payment for lack of medical necessity and you and your health care professional believe the services were medically necessary, you have the right to [file an appeal](#).

### Are experimental, investigational, or cosmetic services medically necessary?

Some definitions of medical necessity specifically state that health care for “experimental, investigational, or cosmetic purposes” isn’t medically necessary. Your health plan’s medical guidelines determine if a treatment or service is considered experimental or investigational for the condition. Some cosmetic treatments may be considered medically necessary if they also have medical purposes. The health plan will follow its medical guidelines and may use medical records to decide if health care is medically necessary. It also may base decisions on the available scientific literature.

### Does medical necessity affect coverage for emergency services?

After you receive emergency services, your health plan will review your case to decide if emergency care was appropriate for your symptoms and medically necessary. To decide, health plans use a “prudent layperson” standard. Getting approval before you receive medical services (prior authorization) isn’t necessary if a [prudent layperson](#) would believe there was an emergency condition and delaying treatment would make that condition worse.

## **Agenda Item #4**

**Hear a Discussion on State-Based Exchange (SBE) Activities:**

- *Georgia—Gregg Conley (GA)*
- *Virginia—Keven Patchett (VA)*




# Georgia Access Exchange

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December 2, 2023

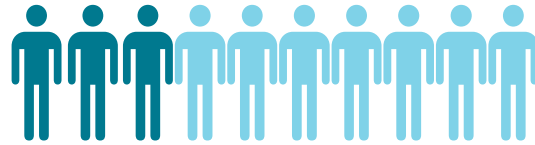
# The Challenge

~1.3m



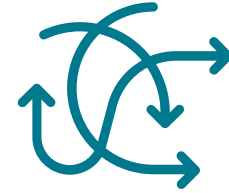
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As of 2021, an estimated 1.3 million\* people in Georgia lacked health insurance, an uninsured rate of 12.7%



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Only 3 in 10 Georgians responsible for purchasing insurance independently did so, as of 2021, through the Federally Facilitated Marketplace (healthcare.gov)



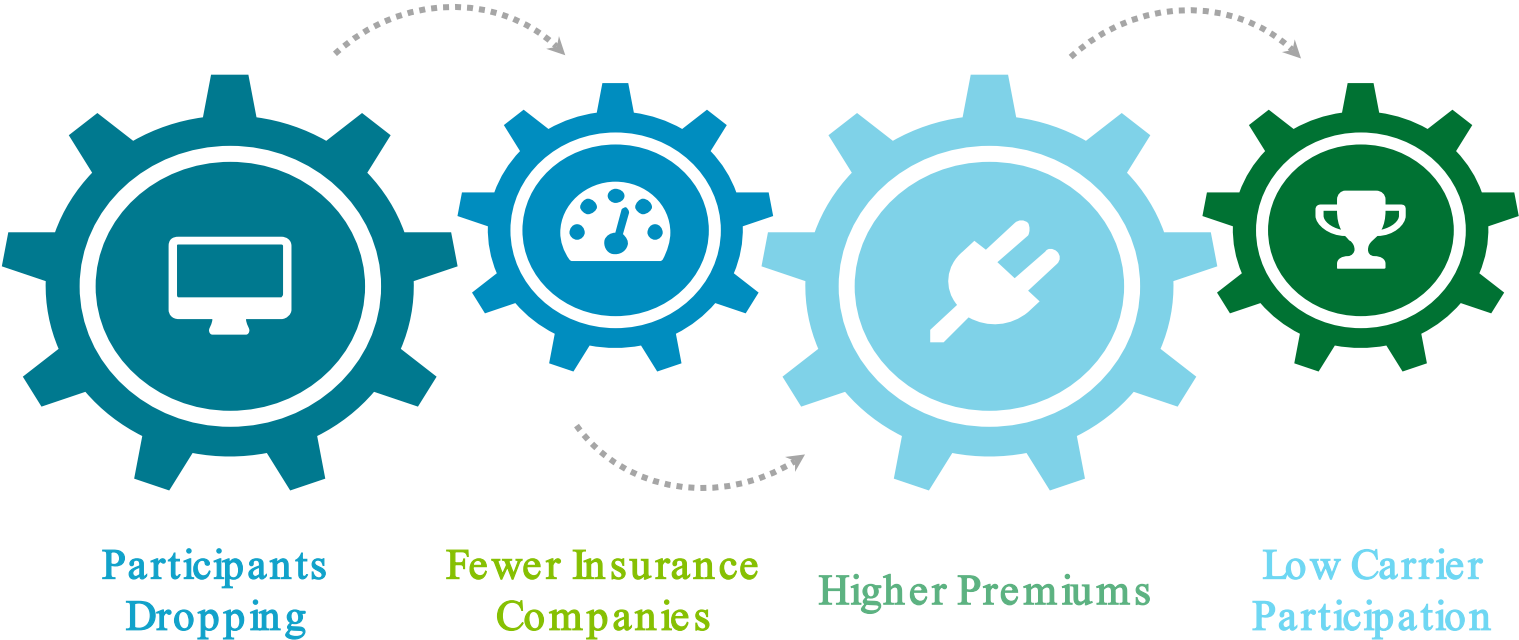
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Households between 100% and 400% of the Federal Poverty Level may qualify for subsidies through the Marketplace, yet many go uninsured. Plans for those near 100% are practically free

# Turn Back the Clock: Insurance Conditions in 2021-2022 Georgia

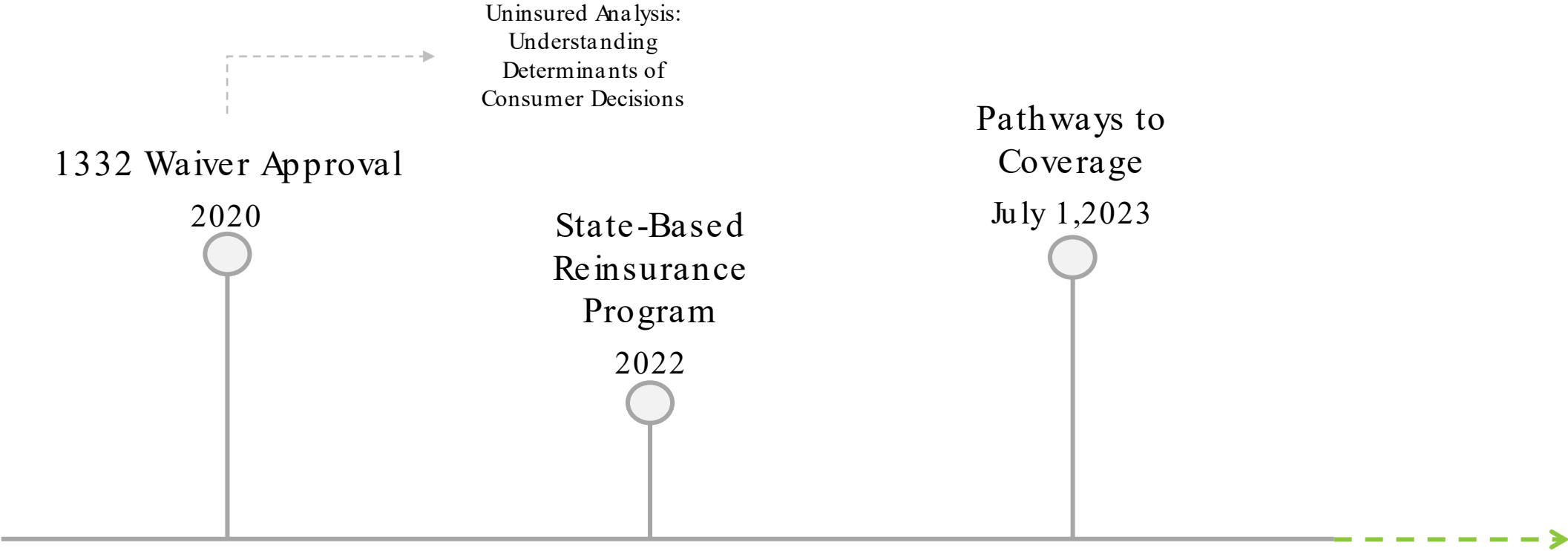
Marketplace enrollment down from 2016 peak

Third-highest rate of uninsured residents in the country





# Uninsured Analysis: One Step in a Broader State Effort



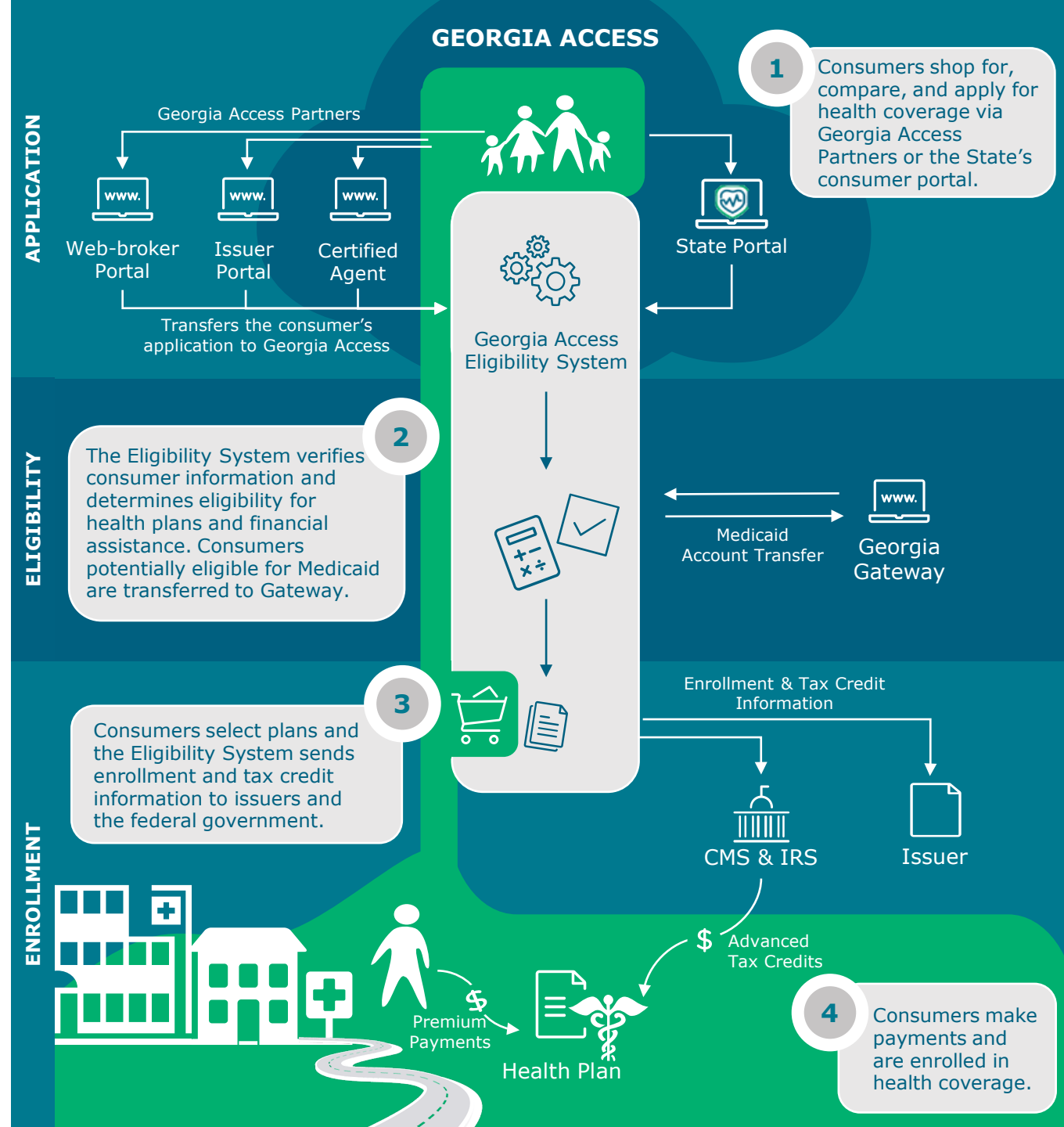
# Georgia Access Exchange

## Overview

Georgia's SBE is designed to serve the needs of its residents; it will facilitate a more competitive marketplace with greater consumer choice by engaging Georgia's private-sector entities to provide innovative solutions for plan shopping, enrollment, and support.

## Program Goals

- Increase competition, innovation, and private sector investment in Georgia's market.
- Improve the shopping and enrollment experience for consumers.
- Reduce the number of uninsured Georgians.



# We Know Our Market

Moving to an SBE builds upon the efforts OCI has recently undertaken to understand and improve the market for consumers. Two recent studies will help direct our efforts with Georgia Access.



## Network Adequacy Analysis

The study assessed the compliance of plans in the individual market with carrier requirements for availability and accessibility to providers.

With an SBE, OCI has more power to hold carriers accountable for failing to maintain their provider networks to ensure patient access.



## Health Market Scan

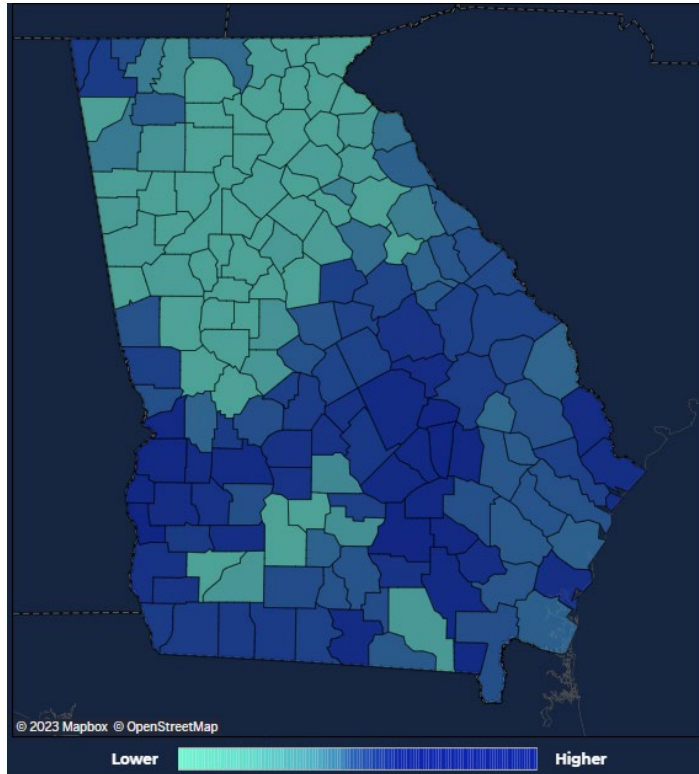
This market scan provides coverage maps to identify the demographics of uninsured populations across the state.

It enables OCI to target known uninsured **“hot spots”** such as Gwinnett County – which has one of the highest rates of eligibility, marketplace participation, and uninsured populations – while limiting marketing and outreach resources in counties that already have high insured populations.

# Network Adequacy Scan | Statewide Snapshot

The following provides a summary of network adequacy for consumers enrolled in the individual market statewide. All findings were calculated based on CMS 2022 drive time requirements, using provider and consumer data submitted by carriers between April 4, 2022, and October 4, 2022.

Coverage Heat Map\*



\*Darker regions correspond with a higher percentage of uncovered consumers

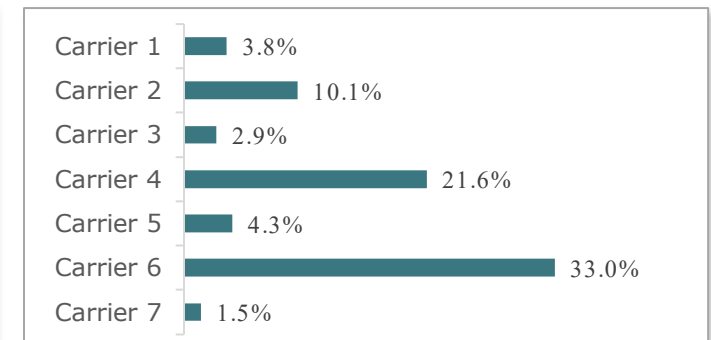
## County Summary

<b>N/A</b> CMS County Designation	<b>644,815</b> Total Consumers	<b>125,368</b> Uncovered Consumers	<b>19.4%</b> of Consumers Uncovered
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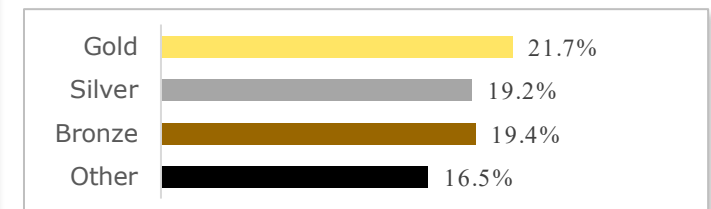
## Top Uncovered Criteria

Criteria	Uncovered Consumer Count	Percent Uncovered
Allergy & Immunology	81,584	12.7%
Dermatology	65,092	10.1%
Neurosurgery	49,454	7.7%
Ophthalmology	48,636	7.5%
Rheumatology	42,954	6.7%
Vascular Surgery	36,871	5.7%
Podiatry	35,786	5.5%
Cardiothoracic Surgery	35,380	5.5%
Oncology – Radiation	34,061	5.3%
Chiropractor	27,248	4.2%

## Uncovered by Carrier



## Uncovered by Plan Level



# Health Market Scan | Gwinnett County Snapshot

Gwinnett County has a large volume of consumers buying on Exchange, but it also has a large volume of uninsured who would be eligible. Taking a closer look at census tracts helps to inform marketing efforts.



TRACT # 13135050526  
BORDERS PLEASANT HILL

Rural (non-core)      Medium metro      Urban (Large central metro)

## INSURANCE METRICS

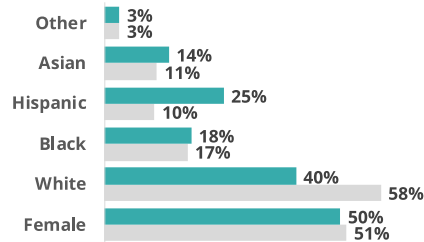
2,836 Total population	9.4% FFM
19.3% Uninsured & Eligible	285% Average FPL

## DISCUSSION

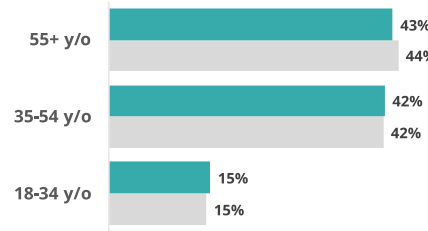
The Gwinnett County tract with the highest rate of uninsured has many Hispanic residents and low homeownership, income, and marriage rates.

## DEMOGRAPHICS

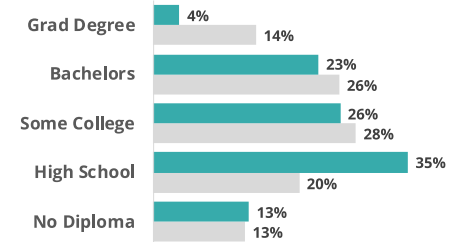
Key: ■ Census Tract ■ Gwinnett County (GC)



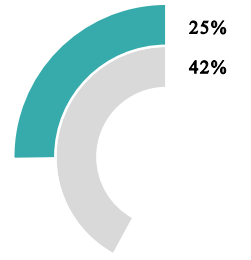
Race Distribution



Age Distribution

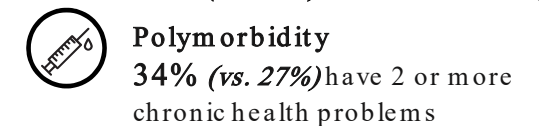
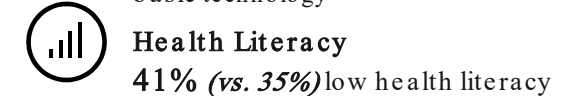
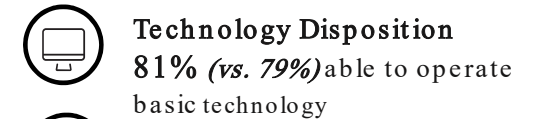
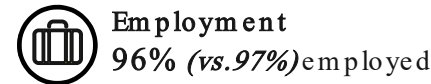
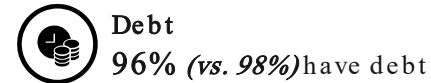
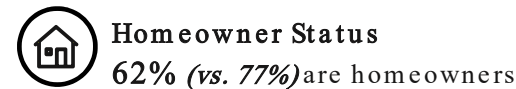
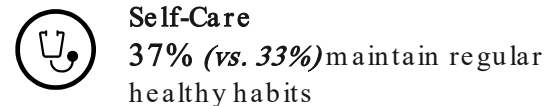
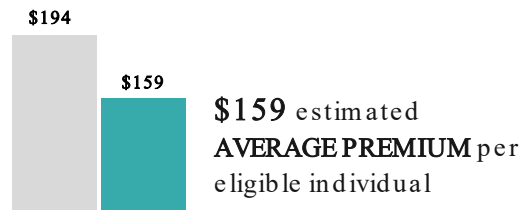


Education Level



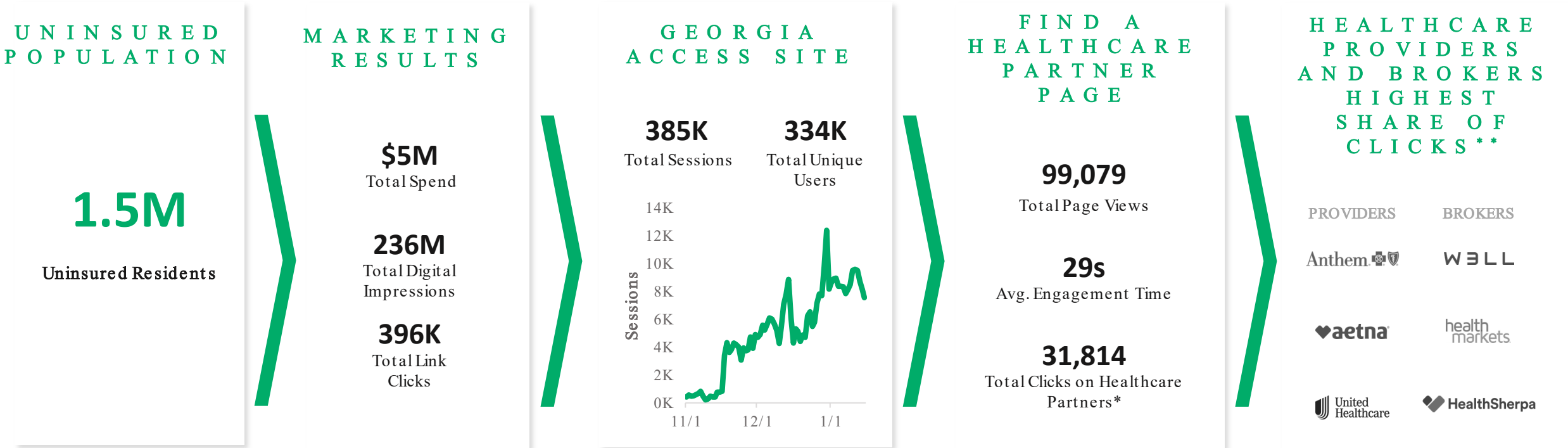
Percent Married

## ACCESS AND HEALTH



# Georgia Access Open Enrollment 2023 Campaign Impact

To understand the impact of the campaign, the State measured key Awareness and Traffic metrics\* from marketing channels and on the GeorgiaAccess.gov site.



**+178K (+25.4%)** *Open enrollment plan selections compared to OE 22*

**879K** *Total open enrollment plan selections in OE 23*

*The open enrollment plan selection growth in Georgia was double the national growth rate average of +12.5%*

\*Awareness is the measure of the reach of GeorgiaAccess.gov messaging across marketing channels, and traffic measures level of link clicks and engagement on the website

\*\*Clicks on Healthcare Partners include clicks to the partner's website and phone number





# Virginia Health Benefit Exchange Status Update

Keven Patchett, Director

December 2, 2023



# What is Virginia's Insurance Marketplace?

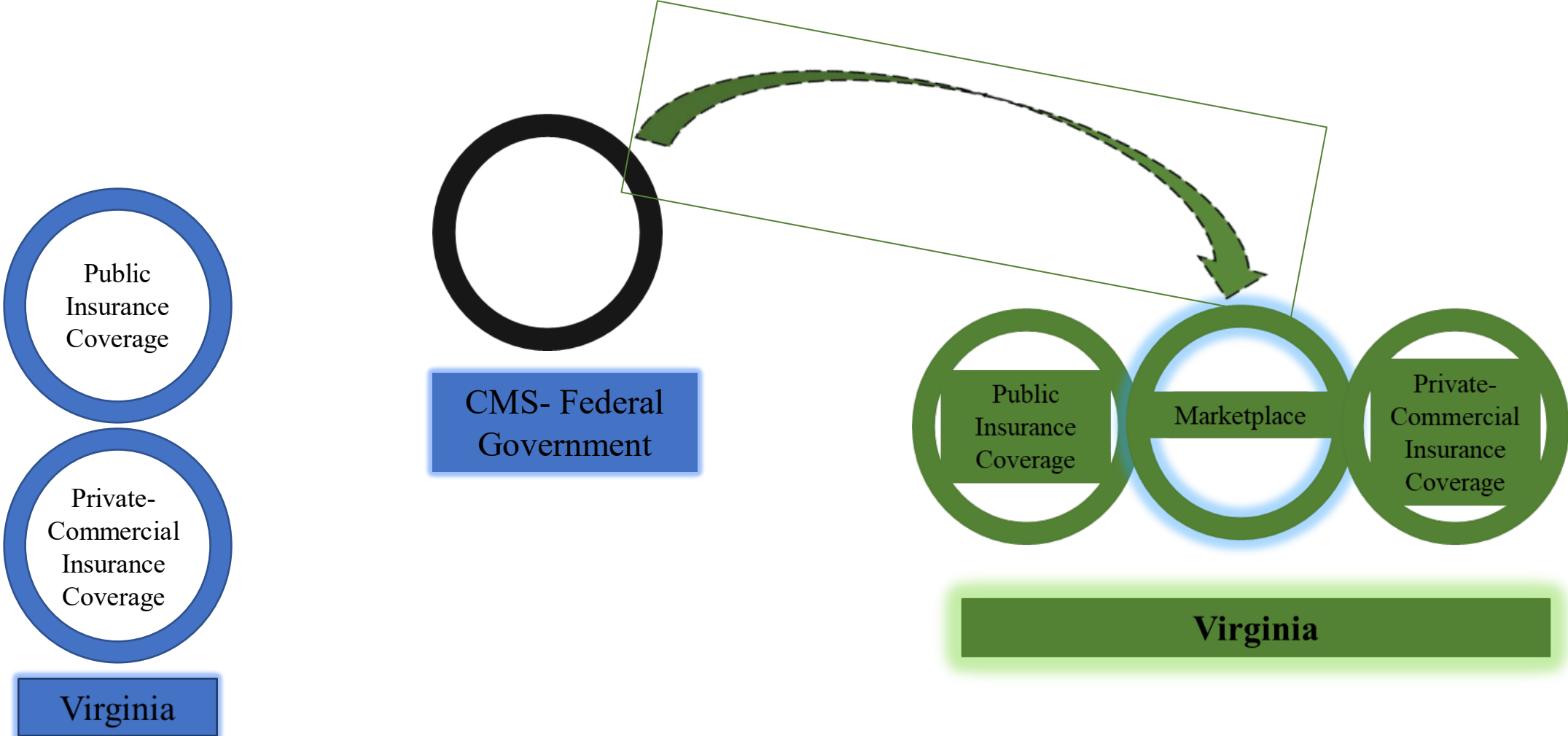
- Virginia's Insurance Marketplace fully replaces HealthCare.gov for Virginia
- A marketplace for Virginia, by Virginians
- Provides health plan shopping and enrollment services for individuals and families

## Statutory goals:

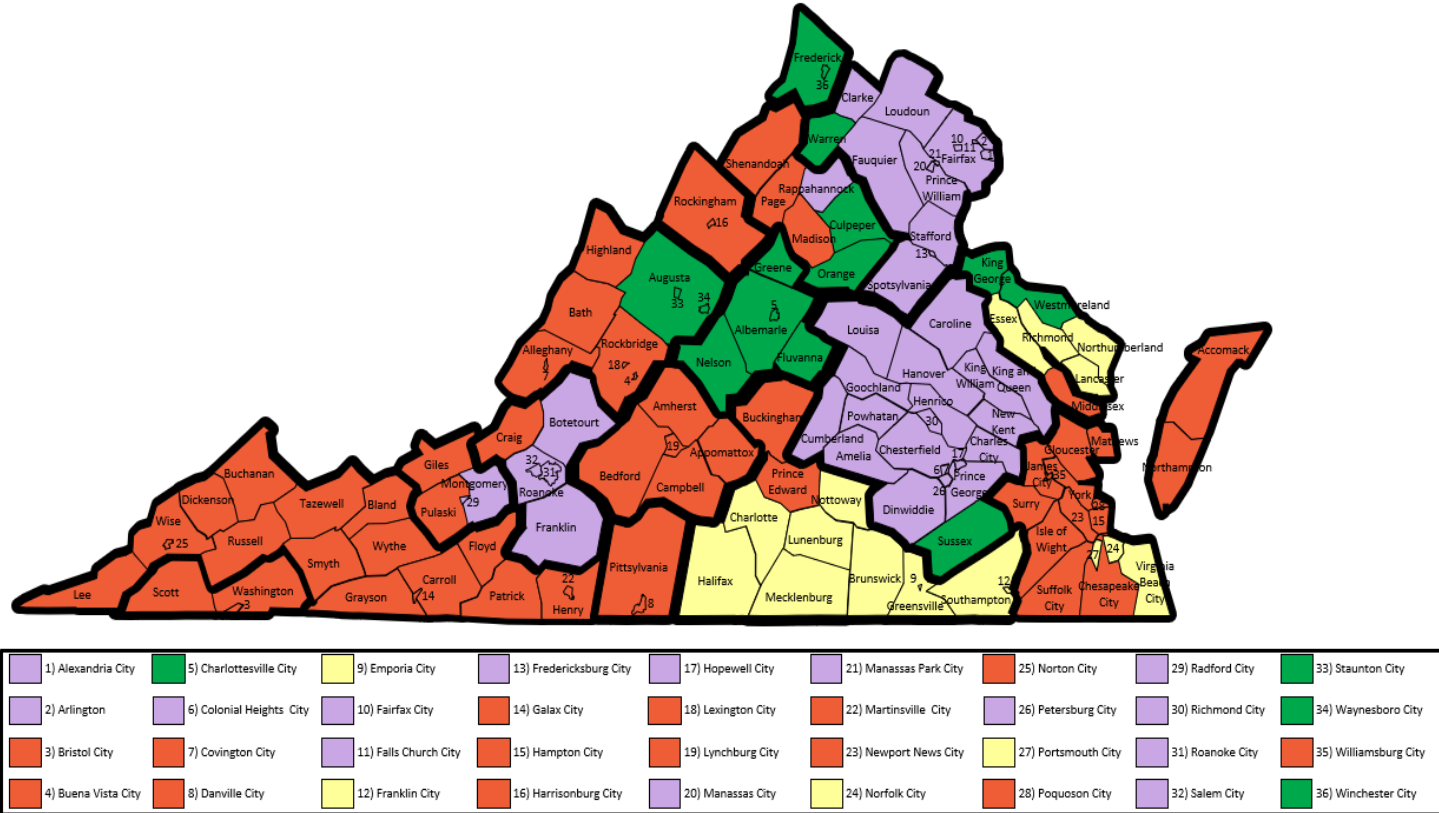
- To more closely coordinate with Virginia state agencies
- To improve coverage transitions from Medicaid to Marketplace
- To reduce the number of uninsured Virginians



# Virginia's Coverage Landscape



# Marketplace Snapshot PY 23 and PY 24



- In PY24, 12 insurers offering individual and family plans in Virginia
- At least two carriers in every county
- PY 2023 - 4/5 Consumers were eligible for plans that are \$10/month or less. Based on available data, there is a similar expectation for 2024.
- PY23 was the first year since 2010 that consumers had the choice of more than one carrier in every county
- 346,140 plan selections through open enrollment in 2023
  - Increase of almost 40,000 over 2022
  - Highest Virginia enrollment since 2018

Health Keepers, Cigna, Sentara Health Plans, Kaiser, Optimum Choice, Innovation Health Plan, Aetna Life, Aetna Health, CareFirst, Anthem, Oscar, GHMSI

# Stand-Alone Dental Plan Coverage

## 2024 Carriers Offering Stand-Alone Dental Plans on Virginia's Insurance Marketplace

### Dental Carriers:

Anthem Health Plans of Virginia, Inc.

Delta Dental of Virginia

DentaQuest National Insurance Company, Inc.

Dominion Dental Services, Inc.

Educators Health Plans Life, Accident & Health

Guardian Life Insurance Company of America

UnitedHealthcare Insurance Company

# Exchange Status

- Over 340,000 consumers from Healthcare.gov re-enrolled on Virginia's Insurance Marketplace
- 3,000 Agents and Brokers certified to sell on Virginia's Insurance Marketplace
- 5,000 Agents, Brokers, Navigators, and Assisters completed VA training
- 21,000 enrollment actions, covering 27,000 consumers taken in first two weeks of OE



A photograph of two men sitting on a couch in a living room, petting a large brown dog. The man on the left is wearing a striped shirt and the man on the right is wearing a brown sweater. They are both smiling and looking at the dog. The room has a lamp, a window with curtains, and some plants.

# Questions?

The logo for Virginia's Insurance Marketplace, featuring a stylized outline of the state of Virginia with a white dot in the center.

Virginia's Insurance  
**Marketplace**

## **Agenda Item #5**

**Hear a Federal Update on Pharmacy Benefit Managers (PBMs), Medicare Advantage (MA) Marketing, Federal Regulations, and Federal Court Cases—*Brian R. Webb (NAIC)***

## **Agenda Item #6**

**Hear an Update from the federal Centers for Medicare & Medicaid Services' (CMS') Center for Consumer Information and Insurance Oversight (CCIIO) on its Recent Activities, including its Medicaid Redetermination Efforts—*Dr. Ellen Montz (CCIIO)***

**Agenda Item #7**

**Discuss Committee Activities and Accomplishments Related to its Priorities for the Year  
—*Director Anita G. Fox (MI)***



**Agenda Item #8**

**Discuss Any Other Matters Brought Before the Committee**  
**—*Director Anita G. Fox (MI)***